SENATE BILL No. 57

Introduced by Senator Aanestad

January 20, 2009

An act to amend Sections 1399.805 and 1399.811 of, and to add and repeal Sections 1356.2 and 1357.55 of, the Health and Safety Code, to amend Sections 10901.3, 10901.9, 12718, 12725, 12727, and 12739 of, to add Sections 12712.5 and 12715.5 to, to add and repeal Sections 10127.19, 10198.11, 12719, 12721.5, 12724, and 12737.5 of, and to add and repeal Chapter 7.5 (commencing with Section 12738.1) of Part 6.5 of Division 2 of, the Insurance Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 57, as introduced, Aanestad. California Major Risk Medical Insurance Program: health care service plans: individual health care coverage.

(1) Existing law establishes the California Major Risk Medical Insurance Program (MRMIP) that is administered by the Managed Risk Medical Insurance Board (MRMIB) to provide major risk medical coverage to residents, as defined, who, among other matters, have been rejected for coverage by at least one private health plan. Existing law authorizes MRMIB to provide that coverage through participating health plans, including health insurers and health care service plans, and authorizes MRMIB to provide or purchase stop-loss coverage under which MRMIP and participating health plans share the risk for health plan expenses that exceed plan rates.

This bill would require that a person either be rejected for coverage by at least 3 different health plans or have a qualified medically uninsurable condition, as specified, in order to be eligible for MRMIP and would also revise the definition of the term "resident" for purposes

of MRMIP eligibility, as specified. The bill would require MRMIB to offer at least 4 different options for major risk medical coverage, including at least one Health Savings Account-compatible option, and would authorize MRMIB to subsidize the Health Savings Account-compatible option, as specified. The bill would also authorize MRMIB, until a specified date and if sufficient funds are available, to participate in deductible and out-of-pocket maximum reinsurance using specified products. The bill would require MRMIB to release all program actuarial data for 2004 to 2007, inclusive, to the Legislative Analyst's Office, as requested by that office.

Existing law specifies the minimum scope of benefits offered by participating health plans in MRMIP and requires the exclusion of benefits that exceed $75,000 in a calendar year or $750,000 in a lifetime, as specified. Existing law requires MRMIB to establish program contribution amounts for each category of risk for each participating health plan. Under existing law, the risk categories are based on age and geographic region.

This bill would, until January 1, 2015, increase the annual benefit limit to $150,000 and the lifetime benefit limit to $1,000,000, and would require the board to adopt regulations eliminating the annual benefit limit if sufficient funds are available, as specified. The bill would authorize MRMIB, by regulation, to develop additional risk categories based on morbid obesity and tobacco use, as specified, and would also require MRMIB to adopt regulations that allow participating health plans to incorporate wellness programs, case management services, and disease management services, and offer enrollee rewards based on health risk reduction. The bill would require that those regulations remain in effect until January 1, 2015.

Existing law creates the Major Risk Medical Insurance Fund, continuously appropriates the fund to MRMIB for purposes of MRMIP, and requires specified moneys to be deposited annually in the fund from the Cigarette and Tobacco Products Surtax Fund.

This bill would increase the moneys to be deposited into the fund from the Cigarette and Tobacco Products Surtax Fund by a specified amount, thereby making an appropriation.

(2) Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the Knox-Keene Act a crime. Existing

law also provides for the regulation of health insurers by the Department of Insurance.

This bill would, commencing July 1, 2010, require each health care service plan and health insurer to add a surcharge to each life covered by an individual health plan contract or individual health insurance policy, as specified, and would require the deposit of those revenues in the Major Risk Medical Insurance Fund, a continuously appropriated fund, thereby making an appropriation. The bill would require the suspension of the assessment if state funds appropriated to MRMIP are less than a certain amount. The bill would require health care service plans and health insurers to report to the Department of Managed Health Care or the Department of Insurance, and MRMIB, the number of lives covered by the plan's or insurer's individual health care service plan contracts or individual health insurance policies annually, as specified. The bill would repeal these provisions on January 1, 2015.

Because a willful violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

Existing law prohibits health care service plan contracts and health insurance policies from excluding coverage on the basis of a preexisting condition provision for more than a specified period of time.

This bill would authorize MRMIB to create a rider pool consisting of applicants with no more than 2 health conditions that made them uninsurable in the private market, as specified. The bill would authorize an individual health care service plan contract or individual health insurance policy issued to one of the rider pool members to temporarily or permanently exclude coverage for those conditions. The bill would repeal these provisions on January 1, 2015.

Existing law requires a health care service plan or a health insurer offering individual plan contracts or individual insurance policies to fairly and affirmatively offer, market, and sell certain individual contracts and policies to all federally eligible defined individuals, as defined, in each service area in which the plan or insurer provides or arranges for the provision of health care services. For those contracts and policies that offer services through a preferred provider arrangement, existing law requires that the premium not exceed the average premium paid by a similar subscriber of MRMIP, as specified. For all other contracts and policies, existing law requires that the premium not exceed 170% of the standard premium charged to a similar individual, as specified.

This bill would require that the premium for all contracts and policies not exceed 170% of the standard premium charged to a similar individual, as specified, regardless of whether services are offered through a preferred provider arrangement, and would make related changes.

Because a willful violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

(3) This bill would result in a change in state taxes for the purpose of increasing state revenues within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of ⅔ of the membership of each house of the Legislature.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: ⅔. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1356.2 is added to the Health and Safety Code, to read:

1356.2. (a) A health care service plan providing coverage for hospital, medical, or surgical benefits under an individual health care service plan contract shall add a surcharge to each life covered by an individual health care service plan contract pursuant to the following schedule:

(1) Beginning July 1, 2010, through June 30, 2011, the surcharge shall be thirty-five cents ($0.35) per life, per month.

(2) Beginning July 1, 2011, through June 30, 2012, the surcharge shall be fifty cents ($0.50) per life, per month.

(3) Beginning July 1, 2012, through June 30, 2013, the surcharge shall be seventy cents ($0.70) per life, per month.

(4) Beginning July 1, 2013, through June 30, 2014, the surcharge shall be eighty-five cents ($0.85) per life, per month.

(5) Beginning July 1, 2014, and thereafter, the surcharge shall be one dollar ($1) per life, per month.

(b) Any increase in the surcharge added pursuant to subdivision (a) shall only be enacted by a statute passed by a two-thirds vote of each house of the Legislature.

(c) The surcharge added pursuant to subdivision (a) shall be deposited in the Major Risk Medical Insurance Fund, created pursuant to Section 12739 of the Insurance Code. Revenues derived from the surcharge added pursuant to this section shall not be considered to be state General Fund proceeds of taxes within the meaning of Article XVI of the Constitution, as they are being held by the state in the Major Risk Medical Insurance Fund as a trustee for the benefit of individuals who are uninsurable on the health insurance market.

(d) On or before May 15 of each year, beginning May 15, 2010, each health care service plan shall report to the department and the Managed Risk Medical Insurance Board the number of lives covered by the plan's individual health care service plan contracts as of March 31 of that year. The surcharge provided for in this section may be paid in two installments. The first installment shall be paid on or before August 1 of each year, and the second installment shall be paid on or before December 15 of each year.

(e) If state funds appropriated to the Major Risk Medical Insurance Program are less than forty million dollars ($40,000,000) for any fiscal year, the surcharge described in subdivision (a) shall be suspended for the subsequent fiscal year.

(f) The surcharge described in subdivision (a) shall be excluded from the computation of a plan's administrative expenses pursuant to Section 1378 or regulations adopted in that regard.

(g) This section shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.

SEC. 2. Section 1357.55 is added to the Health and Safety Code, to read:

1357.55. (a) Notwithstanding Section 1357.51, an individual health care service plan contract issued to a member of the rider pool created pursuant to Section 12738.1 of the Insurance Code may permanently or temporarily exclude coverage for the member's qualifying condition or conditions, as identified in the documentation described in subdivision (b) of Section 12738.1 of the Insurance Code.

(b) This section shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.

SEC. 3. Section 1399.805 of the Health and Safety Code is amended to read:

1399.805. (a) (1) After the federally eligible defined individual submits a completed application form for a plan contract, the plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan contract, unless the plan has provided notice of the premium charge prior to the application being filed. In no case shall the premium charged for any health care service plan contract identified in subdivision (d) of Section 1366.35 exceed ~~the following amounts:~~

~~(A) For health care service plan contracts that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.~~

~~(B) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement,~~ 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium rates.

(2) A plan may adjust the premium based on family size, not to exceed ~~the following amounts:~~

~~(A) For health care service plans that offer services through a preferred provider arrangement, the average of the Major Risk Medical Insurance Program rate for families of the same size that~~

~~reside in the same geographic area as the federally eligible defined individual.~~

~~(B) For health care service plans identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement,~~ 170 percent of the standard premium charged to a family that is of the same size and resides in the same geographic area as the federally eligible defined individual.

(b) When a federally eligible defined individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered or postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(c) During the first 30 days after the effective date of the plan contract, the individual shall have the option of changing coverage to a different plan contract offered by the same health care service plan. If the individual notified the plan of the change within the first 15 days of a month, coverage under the new plan contract shall become effective no later than the first day of the following month. If an enrolled individual notified the plan of the change after the 15th day of a month, coverage under the new plan contract shall become effective no later than the first day of the second month following notification.

SEC. 4. Section 1399.811 of the Health and Safety Code is amended to read:

1399.811. Premiums for contracts offered, delivered, amended, or renewed by plans ~~on or after January 1, 2001,~~ shall be subject to the following requirements:

(a) The premium for new business for a federally eligible defined individual shall not exceed ~~the following amounts:~~

~~(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64 years, inclusive, the premium shall not exceed the average premium paid~~

~~by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.~~

~~(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement,~~ 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64 years, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(b) The premium for in force business for a federally eligible defined individual shall not exceed ~~the following amounts:~~

~~(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64 years, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.~~

~~(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement,~~ 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64 years, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. ~~The premium effective on January 1, 2001, shall apply to in force business at the earlier of either the time of renewal or July 1, 2001.~~

(c) The premium applied to a federally eligible defined individual may not increase by more than the following amounts:

~~(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average increase in the premiums charged to a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual.~~

~~(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement,~~

(1) Except as provided in paragraph (2), the increase in premiums charged to a nonfederally qualified individual who is of the same age and resides in the same geographic area as the federally defined eligible individual. The premium for an eligible individual may not be modified more frequently than every 12 months.

~~(3)~~

(2) For a contract that a plan has discontinued offering, the premium applied to the first rating period of the new contract that the federally eligible defined individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued contract.

SEC. 5. Section 10127.19 is added to the Insurance Code, to read:

10127.19. (a) A health insurer providing coverage for hospital, medical, or surgical benefits under an individual health insurance policy shall add a surcharge to each life covered under an individual health insurance policy pursuant to the following schedule:

(1) Beginning July 1, 2010, through June 30, 2011, the surcharge shall be thirty-five cents ($0.35) per life, per month.

(2) Beginning July 1, 2011, through June 30, 2012, the surcharge shall be fifty cents ($0.50) per life, per month.

(3) Beginning July 1, 2012, through June 30, 2013, the surcharge shall be seventy cents ($0.70) per life, per month.

(4) Beginning July 1, 2013, through June 30, 2014, the surcharge shall be eighty-five cents ($0.85) per life, per month.

(5) Beginning July 1, 2014, and thereafter, the surcharge shall be one dollar ($1) per life, per month.

(b) Any increase in the surcharge added pursuant to subdivision (a) shall only be enacted by a statute passed by a two-thirds vote of each house of the Legislature.

(c) The surcharge shall be deposited in the Major Risk Medical Insurance Fund, created pursuant to Section 12739. Revenues derived from the surcharge added pursuant to this section shall not be considered to be state General Fund proceeds of taxes within the meaning of Article XVI of the Constitution, as they are being held by the state in the Major Risk Medical Insurance Fund as a trustee for the benefit of individuals who are uninsurable on the health insurance market.

(d) On or before May 15 of each year, beginning May 15, 2010, each insurer covered under this section shall report to the department and the Managed Risk Medical Insurance Board the number of lives covered by the insurer's individual health insurance policies as of March 31 of that year. The surcharge provided for in this section may be paid in two installments. The first installment shall be paid on or before August 1 of each year, and the second installment shall be paid on or before December 15 of each year.

(e) If state funds appropriated to the Major Risk Medical Insurance Program are less than forty million dollars ($40,000,000) for any fiscal year, the surcharge described in subdivision (a) shall be suspended for the subsequent fiscal year.

(f) The surcharge described in subdivision (a) shall be excluded from the computation of an insurer's administrative expenses.

(g) This section shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.

SEC. 6. Section 10198.11 is added to the Insurance Code, to read:

10198.11. (a) Notwithstanding Section 10198.7, an individual health insurance policy issued to a member of the rider pool created pursuant to Section 12738.1 may permanently or temporarily exclude coverage for the member's qualifying condition or conditions, as identified in the documentation described in subdivision (b) of Section 12738.1.

(b) This section shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.

SEC. 7. Section 10901.3 of the Insurance Code is amended to read:

10901.3. (a) (1) After the federally eligible defined individual submits a completed application form for a health benefit plan,

the carrier shall, within 30 days, notify the individual of the individual's actual premium charges for that health benefit plan design. In no case shall the premium charged for any health benefit plan identified in subdivision (d) of Section 10785 exceed ~~the following amounts:~~

~~(A) For health benefit plans that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.~~

~~(B) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement,~~ 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium rates.

(2) A carrier may adjust the premium based on family size, not to exceed ~~the following amounts:~~

~~(A) For health benefit plans that offer services through a preferred provider arrangement, the average of the Major Risk Medical Insurance Program rate for families of the same size that reside in the same geographic area as the federally eligible defined individual.~~

~~(B) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement,~~ 170 percent of the standard premium charged to a family that is of the same size and resides in the same geographic area as the federally eligible defined individual.

(b) When a federally eligible defined individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered or postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(c) During the first 30 days after the effective date of the health benefit plan, the individual shall have the option of changing coverage to a different health benefit plan design offered by the same carrier. If the individual notified the plan of the change within the first 15 days of a month, coverage under the new health benefit plan shall become effective no later than the first day of the following month. If an enrolled individual notified the carrier of the change after the 15th day of a month, coverage under the health benefit plan shall become effective no later than the first day of the second month following notification.

SEC. 8. Section 10901.9 of the Insurance Code is amended to read:

10901.9. ~~Commencing January 1, 2001, premiums~~ *Premiums* for health benefit plans offered, delivered, amended, or renewed by carriers shall be subject to the following requirements:

(a) The premium for new business for a federally eligible defined individual shall not exceed ~~the following amounts:~~

~~(1) For health benefit plans identified in subdivision (d) of Section 10785 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.~~

~~(2) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement,~~ 170 percent of the standard premium charged to an individual who is of the same age and resides in the same

geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(b) The premium for in force business for a federally eligible defined individual shall not exceed ~~the following amounts:~~

~~(1) For health benefit plans identified in subdivision (d) of Section 10785 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.~~

~~(2) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement,~~ 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. ~~The premium effective on January 1, 2001, shall apply to in force business at the earlier of either the time of renewal or July 1, 2001.~~

(c) The premium applied to a federally eligible defined individual may not increase by more than the following amounts:

~~(1) For health benefit plans identified in subdivision (d) of Section 10785 that offer services through a preferred provider arrangement, the average increase in the premiums charged to a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual.~~

~~(2) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement,~~

(1) Except as provided in paragraph (2), the increase in premiums charged to a nonfederally qualified individual who is of the same age and resides in the same geographic area as the federally defined eligible individual. The premium for an eligible individual may not be modified more frequently than every 12 months.

(2) For a contract that a carrier has discontinued offering, the premium applied to the first rating period of the new contract that the federally eligible defined individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued contract.

SEC. 9. Section 12712.5 is added to the Insurance Code, to read:

12712.5. The board shall release to the Legislative Analyst's Office all program actuarial data for 2004 to 2007, inclusive, as requested by that office.

SEC. 10. Section 12715.5 is added to the Insurance Code, to read:

12715.5. (a) The board shall offer at least four different options for major risk medical coverage pursuant to this part, including at least one Health Savings Account-compatible option. These options shall provide for both of the following:

(1) Varying deductibles ranging from five hundred dollars ($500) to two thousand five hundred dollars ($2,500) per individual and one thousand dollars ($1,000) to four thousand dollars ($4,000) per family.

(2) Varying out-of-pocket maximums ranging from two thousand five hundred dollars ($2,500) to five thousand dollars ($5,000) per individual and four thousand dollars ($4,000) to seven thousand five hundred dollars ($7,500) per family.

(b) Beginning January 1, 2010, if the board determines that sufficient program funding is available, the board may subsidize the Health Savings Account-compatible option offered pursuant to subdivision (a) on a sliding scale based on income.

SEC. 11. Section 12718 of the Insurance Code is amended to read:

12718. Benefits under this chapter or Chapter 5 (commencing with Section 12720) shall be subject to required subscriber copayments and deductibles as the board may authorize. Any authorized copayments shall not exceed 25 percent ~~and any authorized deductible shall not exceed an annual household deductible amount of five hundred dollars ($500)~~. However, health plans not utilizing a deductible may be authorized to charge an office visit copayment of up to twenty-five dollars ($25). If the board contracts with participating health plans pursuant to Chapter 5 (commencing with Section 12720), copayments or deductibles shall be authorized in a manner consistent with the basic method of operation of the participating health plans. ~~The aggregate amount of deductible and copayments payable annually under this section shall not exceed two thousand five hundred dollars ($2,500) for an individual and four thousand dollars ($4,000) for a family.~~

SEC. 12. Section 12719 is added to the Insurance Code, to read:

12719. (a) Major risk medical coverage in the program shall have an annual limit on total coverage or benefits for each subscriber of one hundred fifty thousand dollars ($150,000). However, if the board determines that sufficient program funds are available, the board shall adopt regulations that become effective on or before January 1, 2011, that eliminate this limit.

(b) Major risk medical coverage in the program shall have a limit on covered benefits over the lifetime of each subscriber of one million dollars ($1,000,000).

(c) This section shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.

SEC. 13. Section 12721.5 is added to the Insurance Code, to read:

12721.5. (a) If the board determines there are sufficient funds available, it may participate, on a sliding scale based on income, in deductible and out-of-pocket maximum reinsurance using products including, but not limited to, health reimbursement arrangements, critical insurance policies, and accident insurance policies.

(b) This section shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.

SEC. 14. Section 12724 is added to the Insurance Code, to read:

12724. (a) The board shall adopt regulations that allow participating health plans to incorporate wellness programs, case management services, and disease management services, and offer enrollee rewards based on health risk reduction. The regulations adopted by the board pursuant to this section shall remain in effect only until January 1, 2015.

(b) This section shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.

SEC. 15. Section 12725 of the Insurance Code is amended to read:

12725. (a) Each resident of the state meeting the eligibility criteria of this section and who is unable to secure adequate private health coverage is eligible to apply for major risk medical coverage through the program. ~~For these purposes, "resident" includes a member of a federally recognized California Indian tribe.~~

(b) To be eligible for enrollment in the program, an applicant shall have been rejected for health care coverage by at least ~~one~~ *three different* private health ~~plan~~ *plans or shall provide proof that he or she has a qualified medically uninsurable condition, as documented by a physician and surgeon. The board shall determine, by regulation, which conditions are qualified for purposes of this section*. An applicant shall be deemed to have been rejected if the only private health coverage that the applicant could secure would do one of the following:

(1) Impose substantial waivers that the program determines would leave a subscriber without adequate coverage for medically necessary services.

(2) Afford limited coverage that the program determines would leave the subscriber without adequate coverage for medically necessary services.

(3) Afford coverage only at an excessive price, which the board determines is significantly above standard average individual coverage rates.

(c) Rejection for policies or certificates of specified disease or policies or certificates of hospital confinement indemnity, as described in Section 10198.61, shall not be deemed to be rejection for the purposes of eligibility for enrollment.

(d) The board may permit dependents of eligible subscribers to enroll in major risk medical coverage through the program if the board determines the enrollment can be carried out in an actuarially and administratively sound manner.

(e) Notwithstanding the provisions of this section, the board shall by regulation prescribe a period of time during which a resident is ineligible to apply for major risk medical coverage through the program if the resident either voluntarily disenrolls from, or was terminated for nonpayment of the premium from, a private health plan after enrolling in that private health plan pursuant to either Section 10127.15 or Section 1373.62 of the Health and Safety Code.

(f) For the period commencing September 1, 2003, to December 31, 2007, inclusive, subscribers and their dependents receiving major risk coverage through the program may receive that coverage for no more than 36 consecutive months. Ninety days before a subscriber or dependent's eligibility ceases pursuant to this subdivision, the board shall provide the subscriber and any dependents with written notice of the termination date and written information concerning the right to purchase a standard benefit plan from any health care service plan or health insurer participating in the individual insurance market pursuant to Section 10127.15 or Section 1373.62 of the Health and Safety Code. This subdivision shall become inoperative on December 31, 2007.

(g) (1) For purposes of this section, "resident" means a person who meets one of the following requirements:

(A) Has resided continuously in the State of California for at least six months immediately prior to applying to the program.

(B) Is present in the State of California and provides documentation of recent participation in a high-risk health insurance program in another state.

(2) "Resident" includes a member of a federally recognized California Indian tribe who meets the requirements of subparagraph (A) or (B) of paragraph (1).

SEC. 16. Section 12727 of the Insurance Code is amended to read:

12727. ~~Where more than one participating health plan is offered, the~~ *The* program shall make available to applicants eligible to enroll in the program sufficient information to make an informed choice among the ~~various types of participating health plans~~ *options*

provided pursuant to Section 12715.5. Each applicant shall be issued an appropriate document setting forth or summarizing the services to which an enrollee is entitled, procedures for obtaining major risk medical coverage, a list of contracting health plans and providers, and a summary of grievance procedures.

SEC. 17. Section 12737.5 is added to the Insurance Code, to read:

12737.5. (a) In addition to the risk categories described in Section 2698.400 of Title 10 of the California Code of Regulations, the board may, by regulation, develop risk categories based on morbid obesity and tobacco use. The risk categories developed pursuant to this section shall set objectives for the reduction of morbid obesity and tobacco use and shall allow for rate reductions if those objectives are achieved.

(b) The regulations adopted by the board pursuant to this section shall remain in effect only until January 1, 2015.

(c) This section shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.

SEC. 18. Chapter 7.5 (commencing with Section 12738.1) is added to Part 6.5 of Division 2 of the Insurance Code, to read:

Chapter 7.5. Rider Pool

12738.1. (a) The board may create a rider pool consisting of applicants with no more than two qualifying conditions.

(b) The board shall issue documentation of membership to each member of the rider pool. This documentation shall identify the member's qualifying condition or conditions.

(c) For purposes of this section, "qualifying condition" means a health condition that made the individual uninsurable in the private market, as determined by the board, and that the board determines, by regulation, is eligible for purposes of this section. "Qualifying condition" shall not include a condition likely to require chronic, ongoing care.

12738.2. This chapter shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.

SEC. 19. Section 12739 of the Insurance Code is amended to read:

12739. (a) There is hereby created in the State Treasury a special fund known as the Major Risk Medical Insurance Fund that is, notwithstanding Section 13340 of the Government Code, continuously appropriated to the board for the purposes specified in ~~Sections 10127.15 and~~ *Section* 12739.1 ~~and Section 1373.62 of the Health and Safety Code~~.

(b) After June 30, ~~1991~~ *2010*, the following amounts shall be deposited annually in the Major Risk Medical Insurance Fund:

(1) ~~Eighteen~~ *Twenty-three* million dollars ~~($18,000,000)~~ *($23,000,000)* from the Hospital Services Account in the Cigarette and Tobacco Products Surtax Fund.

(2) ~~(A) Eleven~~ *Sixteen* million dollars ~~($11,000,000)~~ *($16,000,000)* from the Physician Services Account in the Cigarette and Tobacco Products Surtax Fund.

~~(B) Notwithstanding subparagraph (A), for the 2007–08 fiscal year only, the Controller shall reduce the amount deposited into the Major Risk Medical Insurance Fund from the Physician Services Account in the Cigarette and Tobacco Products Surtax Fund to one million dollars ($1,000,000).~~

(3) One million dollars ($1,000,000) from the Unallocated Account in the Cigarette and Tobacco Products Surtax Fund.

SEC. 20. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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